Exhibit 1

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA**

**CHARLESTON DIVISION**

*MDL No. 2327*
*In Re Ethicon Inc., Pelvic Repair System Products Liability Litigation*

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In completing this Plaintiff Profile Form, you are under oath and must provide information that is true and correct to the best of your knowledge. The Plaintiff Profile Form shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order.

## I. CASE INFORMATION

**Caption:** ______________________ **Date:** ______________

**Docket No.**: ______________________

**Plaintiff's attorney and Contact information:**

______________________

______________________

______________________

______________________

## II. PLAINTIFF INFORMATION

**Name**: ______________________

**Spouse**: ______________________ **Loss of Consortium?** ☐**Yes** ☐ **No**

**Address**: ______________________

**Date of birth**: ______________________

**Social Security No.:** ______________________

## III. DEVICE INFORMATION[1]

**Date of implant**: ______________________

***Reason for Implantation***: ______________________

**Brand Name**: ______________________ **Mfg.** ______________

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[1] Note: In lieu of device information, operating records may be submitted as long as all requested information is legible on the face of the record.

**Lot Number:** ____________________

**Implanting Surgeon**: ____________________

**Medical Facility**: ____________________

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**Date of implant**: ____________________

***Reason for Implantation***: ____________________

**Brand Name**: ____________________ **Mfg.** ____________

**Implanting Surgeon**: ____________________

**Medical Facility**: ____________________

• ***Attach medical evidence of product identification.***

## IV. REMOVAL/REVISION SURGERY INFORMATION

**Date of surgery(s)**: ____________________

***Type of surgery(s)***: ____________________

**Explanting surgeon**: ____________________

**Medical Facility**: ____________________

**Reason for Explant:** ____________________

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**Date of surgery(s)**: ____________________

***Type of surgery(s)***: ____________________

**Explanting surgeon**: ____________________

**Medical Facility**: ____________________

**Reason for Explant:** ____________________

## V. OUTCOME ATTRIBUTED TO DEVICE

| | |
|---|---|
| ☐ **Pain** | ☐ **Fistulae** |
| ☐ **Erosion** | ☐ **Recurrence** |
| ☐ **Extrusion** | ☐ **Bleeding** |
| ☐ **Infection** | ☐ **Dyspareunia** |
| ☐ **Urinary Problems** | ☐ **Neuromuscular problems** |
| ☐ **Bowel Problems** | ☐ **Vaginal Scarring** |

| | |
|---|---|
| ☐ **Organ Perforation** | ☐ **Other** |

## VI. PAST HISTORY

**Number of Pregnancies:** ____ **Number of Live Births:** ____

**Date of Hysterectomy(ies) and Name of Hospital Where Performed:** ____

**Prior to the First Implant, Have You Ever Had:**

____ **Lupus**
____ **Diabetes**
____ **Auto Immune Disorder**
____ **Endometriosis**
____ **Pelvic Pain Syndrome or Disorder**
____ **Fibroids**
____ **Adhesive Disease**

**Are you claiming damages for lost wages: [ ] Yes [ ] No**

**If so, for what time period:** ____

**Have you ever filed for bankruptcy: [ ] Yes [ ] No**

**If so, when?** ____

**Do you have a computer: [ ] Yes [ ] No**

**If so, are you a member of Facebook, LinkedIn or other social media websites:**
**[ ] Yes [ ] No**

**Which ones:** ____

## VII. LIST OF ALL TREATING PHYSICIANS FOR THE PERIOD OF 10 YEARS PRIOR TO THE FIRST MESH IMPLANT, INCLUDING ALL PRIMARY CARE PHYSICIANS, OB-GYNS, UROLOGISTS, ENDOCRINOLOGISTS, RHEUMATOLOGISTS, PSYCHIATRISTS, PSYCHOLOGISTS, OR ANY OTHER SPECIALISTS

**Primary Care Physicians:**

**Name:** ____

**Address:** ____

**Approximate Period of Treatment:** ____

**Name:** ____________________

**Address:** ____________________

**Approximate Period of Treatment:** ____________________

**OB-GYNs:**

**Name:** ____________________

**Address:** ____________________

**Approximate Period of Treatment:** ____________________

**Name:** ____________________

**Address:** ____________________

**Approximate Period of Treatment:** ____________________

**Urologists:**

**Name:** ____________________

**Address:** ____________________

**Approximate Period of Treatment:** ____________________

**Name:** ____________________

**Address:** ____________________

**Approximate Period of Treatment:** ____________________

**Psychiatrists/Psychologists (Answer only if making a claim for emotional/psychological Injury beyond usual pain and suffering):**

**Name:** ____________________

**Address:** ____________________

**Approximate Period of Treatment:** ____________________

**Name:** ______________________________

**Address:** ______________________________

**Approximate Period of Treatment:** ______________________________

**Attach additional pages as needed to identify other health care providers you have seen.**

## AUTHORIZATIONS

Provide ONE (1) SIGNED ORIGINAL copy of each of the records authorization forms attached as Ex. A. These authorization forms will authorize the records vendor selected by the parties to obtain those records identified in the authorizations from the providers identified within this Plaintiff Profile Form.

## VERIFICATION

I, ______________________________, declare under penalty of perjury subject to all applicable laws, that I have carefully reviewed the final copy of this Plaintiff Profile Form dated __________ and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

______________________________
Signature of Plaintiff